

Administrative

MEDICAL CLAIM FORM

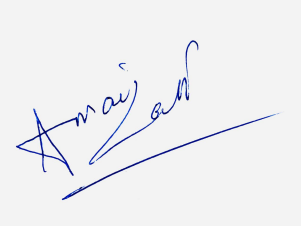
Claim Ref:

Patient Name : MOHAMMED SHAHAB UDDIN ABDUL MABUD
 Card No : I040-029-119600415-01
 Policy Holder : MOHAMMED SHAHAB UDDIN ABDUL MABUD
 Payer Name : UNION INSURANCE COMPANY
 TPA : E CARE - Blue Network
 Validity : 02-01-2025 To 01-01-2026
 Gender : Male
 Date Of Birth : 08-Mar-1985
 Patient's Tel No : 0581676397

Service Date : 24-Jun-2025 Network : Green
 Health Provider : CITICARE MEDICAL CENTER LLC Direct Access SP - YES
 Doctor's Name : DR Amaizah

Co-Insurance	CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
	10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ Acute ☐ Pre-existing and chronic ☐ Maternity	
Chief Complaints : pc : pain in both ears associated with serous secretions from both ears started 17/06/25 previously fubgal infection of skin o/e : serous fluid filled in ear canal white and yellow patches Duration:	
Vitals: Temp : 36.2 Bp :126 Pulse :71 Resp :18	
Clinical Findings:	
Diagnosis: H66.017 - Ac suppr otitis media w spon rupt ear drum, recur, unsp ear,R50.9 - Fever, unspecified,R21 - Rash and other nonspecific skin eruption,B35.0 - Tinea barbae and tinea capitis,	
Requested Investigations: 0195-107704-0801, CEFTRIAXONE-TABUK IV,0125-122107-1022, DEXAMETHASONE SODIUM PHOSPHATE,0005-111805-1021, CHLOROHISTOL 10MG,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,96372, THER/PROPH/DIAG INJ SC/IM,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP	
Prescriptions: 0397-116206-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 875 MG) TABLETS,0195-123701-0391 - (CETIRIZINE HCL : 10 MG) FILM COATED TABLETS,0355-103204-1681 - (CIPROFLOXACIN : 0.3%) EYE / EAR DROPS,7048-140201-0061 - (FLUCONAZOLE : 150 MG) CAPSULES,	
MEDICAL PRACTITIONER DECLARATION : I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.	
PATIENT'S DECLARATION : I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.	
Dr's Name : DR Amaizah	Stamp : Dr. Amaizah Ishtiaq General Practitioner DHA: 98486553-001 CITICARE MEDICAL CENTER DUBAI - U.A.E
Signature : 	Patient 's signature{Parent : if minor} 
Date : 24-Jun-2025	Date : Jun-2025